



September 2013

## DEFENSE HEALTH CARE

# Evaluation of TRICARE Pharmacy Services Contract Structure Is Warranted

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Highlights of GAO-13-808, a report to the Committee on Armed Services, U.S. Senate

September 2013

## DEFENSE HEALTH CARE

### Evaluation of TRICARE Pharmacy Services Contract Structure Is Warranted

#### Why GAO Did This Study

DOD offers health care coverage—medical and pharmacy services—to eligible beneficiaries through its TRICARE program. DOD contracts with managed care support contractors to provide medical services, and separately with a pharmacy benefit manager to provide pharmacy services that include the TRICARE mail-order pharmacy and access to a retail pharmacy network. This is referred to as a carve-out contract structure. DOD's current pharmacy contract ends in the fall of 2014. DOD has been preparing for its upcoming contract through acquisition planning, which included identifying any needed changes to contract requirements.

Senate Report 112-173, which accompanied a version of the NDAA for fiscal year 2013, mandated that GAO review DOD's health care contracts. For this report, GAO examined: (1) how DOD identified changes needed, if any, to requirements for its upcoming pharmacy services contract; and (2) what, if any, assessment DOD has done of the appropriateness of its current contract structure. GAO reviewed DOD acquisition planning documents and federal regulations, and interviewed officials from DOD and its pharmacy services contractor.

#### What GAO Recommends

GAO recommends that DOD conduct an evaluation of the potential costs and benefits of alternative structures for the TRICARE pharmacy services contract, and incorporate such an evaluation into acquisition planning. DOD concurred with GAO's recommendations.

View GAO-13-808. For more information, contact Debra A. Draper at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov).

#### What GAO Found

The Department of Defense (DOD) used various methods to identify needed changes to requirements for its upcoming pharmacy services contract. During acquisition planning for the upcoming TRICARE pharmacy services contract, DOD solicited feedback from industry through its market research process to align the contract requirements with industry best practices and promote competition. For example, DOD issued requests for information (RFI) in which DOD asked questions about specific market trends, such as ensuring that certain categories of drugs are distributed through the most cost-effective mechanism. DOD also issued an RFI to obtain information on promoting competition, asking industry for opinions on the length of the contract period. DOD officials told us that responses indicated that potential offerors would prefer a longer contract period because it would allow a new contractor more time to recover any capital investment made in implementing the contract. The request for proposals for the upcoming contract, issued in June 2013, included a contract period of 1 base year and 7 option years. DOD also identified changes to contract requirements in response to legislative changes to the TRICARE pharmacy benefit. For example, the National Defense Authorization Act (NDAA) for fiscal year 2013 required DOD to implement a mail-order pilot for maintenance drugs for beneficiaries who are also enrolled in Medicare Part B. DOD officials incorporated this change in the requirements for the upcoming pharmacy services contract.

DOD has not conducted an assessment of the appropriateness of its current pharmacy services contract structure that includes an evaluation of the costs and benefits of alternative structures. Alternative structures can include incorporating all pharmacy services into the managed care support contracts—a carve-in structure—or a structure that incorporates certain components of DOD's pharmacy services, such as the mail-order pharmacy, into the managed care support contracts while maintaining a separate contract for other components. DOD officials told GAO they believe that DOD's current carve-out contract structure continues to be appropriate, as it affords more control over pharmacy data that allows for detailed data analyses and cost transparency, meets program goals, and has high beneficiary satisfaction. However, there have been significant changes in the pharmacy benefit management market in the past decade, including mergers and companies offering new services that may change the services and options available to DOD. GAO has previously reported that sound acquisition planning includes an assessment of lessons learned to identify improvements. Additionally, GAO has reported that a comparative evaluation of the costs and benefits of alternatives can provide an evidence-based rationale for why an agency has chosen a particular alternative. Without this type of evaluation, DOD cannot effectively demonstrate that it has chosen the most appropriate contract structure in terms of costs to the government and services for beneficiaries.

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## **Abbreviations**

COR	contracting officer's representative
DFARS	Defense Federal Acquisition Regulation Supplement
DOD	Department of Defense
FAR	Federal Acquisition Regulation
NDAA	National Defense Authorization Act
RFI	request for information
RFP	request for proposals

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.  
Washington, DC 20548

September 30, 2013

The Honorable Carl Levin  
Chairman  
The Honorable James M. Inhofe  
Ranking Member  
Committee on Armed Services  
United States Senate

In fiscal year 2012, the Department of Defense's (DOD) military health system offered comprehensive health care coverage—including a pharmacy benefit—to nearly 9.7 million eligible beneficiaries through its TRICARE program.<sup>1</sup> DOD's pharmacy benefit allows TRICARE beneficiaries to obtain prescription drugs either from military treatment facility pharmacies operated by DOD or from TRICARE's mail-order and retail pharmacies operated through the private sector. In its current contract structure, DOD contracts with managed care support contractors to provide medical services,<sup>2</sup> and contracts separately with a pharmacy benefit manager, Express Scripts, Inc., to operate the TRICARE mail-order pharmacy and provide access to a retail pharmacy network. DOD's current pharmacy services contract is set to expire in the fall of 2014, and DOD has issued a request for proposals (RFP) for its next pharmacy services contract,<sup>3</sup> which it estimates will cost a total of \$4.4 billion.

DOD has been preparing for its upcoming pharmacy services contract through its acquisition planning process, which included identifying any planned changes to contract requirements—the work to be performed by the contractor. Federal regulations require agencies to perform acquisition planning activities for all contracts to ensure that the

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<sup>1</sup>Eligible beneficiaries include active duty personnel and their dependents, Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors.

<sup>2</sup>DOD contracts with managed care support contractors in three regions to provide networks of private sector providers for TRICARE and to perform other customer service functions, such as processing claims and assisting beneficiaries with finding providers.

<sup>3</sup>The RFP was issued in June 2013, and proposals are due October 7, 2013. The upcoming contract is scheduled to begin November 1, 2013, and includes 1 base year and 7 option years. The base year is a transition period and overlaps with the last year of the current contract.

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government meets its needs in the most effective, economical, and timely manner possible.<sup>4</sup> We have previously reported that inadequate acquisition planning can increase the risk that the government may receive services that cost more than anticipated, are delivered late, and are of unacceptable quality.<sup>5</sup> Federal regulations also allow agencies to make changes to requirements in existing contracts, as needed.<sup>6</sup>

Senate Report 112-173, which accompanied the Senate Armed Services Committee's version of the National Defense Authorization Act (NDAA) for fiscal year 2013, mandated that GAO conduct a comprehensive review of DOD's health care contracts,<sup>7</sup> which include the pharmacy services contract. In this report, we review: (1) how DOD identified changes needed, if any, to requirements for its upcoming and current pharmacy services contracts; and (2) what, if any, assessment DOD has done of the appropriateness of its current pharmacy services contract structure.

To determine the steps DOD took to identify changes needed, if any, to contract requirements, we focused on DOD's preparation for the upcoming contract and administration of the current contract. We reviewed documents related to DOD's acquisition planning, including market research documentation and the draft and final RFP for the upcoming contract. We also reviewed relevant federal regulations, including the Federal Acquisition Regulation (FAR) and Defense Federal Acquisition Regulation Supplement (DFARS),<sup>8</sup> as they relate to

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<sup>4</sup>Federal Acquisition Regulation (FAR) § 7.102. The FAR defines acquisition planning as the process by which the efforts of all personnel responsible for an acquisition are coordinated and integrated through a comprehensive plan for fulfilling the agency need in a timely manner and at a reasonable cost. It includes developing the overall strategy for managing the acquisition. FAR § 2.101.

<sup>5</sup>See GAO, *Acquisition Planning: Opportunities to Build Strong Foundations for Better Services Contracts*, GAO-11-672 (Washington, D.C.: Aug. 9, 2011).

<sup>6</sup>FAR § 43.103. Contract modifications may be either bilateral or unilateral. The FAR limits unilateral changes to those that are within the general scope of the contract. FAR § 43.201.

<sup>7</sup>S. Rep. No. 112-173, at 131-32 (2012).

<sup>8</sup>The FAR codifies uniform policies for the acquisition of supplies and services across the federal government, and the DFARS contains further implementing regulations for the FAR for DOD, including DOD-wide policies, delegations of FAR authorities, and deviations from FAR requirements.

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acquisition planning. We interviewed DOD officials about their acquisition planning efforts, including changes to the contract requirements they determined were necessary and the reasons for those changes. We also interviewed officials from DOD's current pharmacy services contractor about the department's efforts to solicit industry feedback in making changes to requirements for the pharmacy services contract. In addition, we interviewed officials from the Pharmaceutical Care Management Association (the trade group representing the pharmacy benefit manager industry, including Express Scripts) and Pharmaceutical Strategies Group (a pharmacy benefit consulting organization) to obtain their perspectives on industry trends and DOD's process for obtaining industry input.

To determine what, if any, assessment DOD has done of the appropriateness of its current pharmacy services contract structure, we reviewed DOD documents, including congressional testimony and projected cost estimates related to the initial decision to contract for pharmacy services separately from its managed care support contracts—referred to as a carve-out contract structure. In addition, we interviewed DOD officials about the reasoning behind this decision. We also reviewed DOD documents, including the report from the Task Force on the Future of Military Health Care that made recommendations regarding the structure of the pharmacy services contract, and DOD's official response to the report.<sup>9</sup> We also interviewed DOD officials about any efforts to determine whether the current carve-out structure continues to be appropriate. We analyzed these documents in the context of GAO's *Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*,<sup>10</sup> which provides guidance to the federal government on cost-benefit analysis. We interviewed officials from DOD's three current managed care support contractors to obtain their perspectives on the current pharmacy services contract structure. We also reviewed health plan research literature and interviewed officials from the two industry groups described above about industry practices.

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<sup>9</sup>See Department of Defense, *Final Report of the Task Force on the Future of Military Health Care* (Washington, D.C.: December 2007) and Department of Defense Military Health System Senior Oversight Committee, *Response to the Recommendations of the Task Force on the Future of Military Health Care* (Washington, D.C.: January 2009).

<sup>10</sup>GAO, *Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, [GAO-09-3SP](#) (Washington, D.C.: March 2009).

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We conducted this performance audit from February 2013 to September 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

TRICARE beneficiaries used the program's pharmacy benefit to fill almost 134 million outpatient prescriptions in fiscal year 2012. Through its acquisition process, DOD contracts with a pharmacy benefit manager—currently Express Scripts—to provide access to a retail pharmacy network and operate a mail order pharmacy for beneficiaries, and to provide administrative services.

## TRICARE's Pharmacy Benefit

Under TRICARE, beneficiaries have three primary health plan options in which they may participate: (1) a managed care option called TRICARE Prime, (2) a preferred-provider option called TRICARE Extra, and (3) a fee-for-service option called TRICARE Standard.<sup>11</sup> TRICARE beneficiaries may obtain medical care through a direct-care system of military treatment facilities or a purchased-care system consisting of network and non-network private sector primary and specialty care providers, and hospitals. In addition, TRICARE's pharmacy benefit—offered under all TRICARE health plan options—provides beneficiaries with three options for obtaining prescription drugs: from military treatment facility pharmacies, from network and non-network retail pharmacies, and through the TRICARE mail-order pharmacy.

TRICARE's pharmacy benefit has a three-tier copayment structure based on whether a drug is included in DOD's formulary and the type of pharmacy where the prescription is filled. (See table 1.) DOD's formulary includes a list of drugs that all military treatment facilities must provide, and a list of drugs that military treatment facilities may elect to provide on the basis of the types of services offered at that facility (e.g., cancer drugs

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<sup>11</sup>In addition, retirees and their family members may obtain coverage through TRICARE for Life, which offers additional coverage to beneficiaries enrolled in Medicare Part B. TRICARE for Life covers most costs not covered by Medicare, including Medicare's coinsurance and deductible.

at facilities that provide cancer treatment).<sup>12</sup> DOD also can classify drugs as “non-formulary” on the basis of its evaluation of their cost and clinical effectiveness. Non-formulary drugs are available to beneficiaries at a higher cost, unless the provider can establish medical necessity.

**Table 1: TRICARE Pharmacy Copayments/Coinsurance by Type of Prescription, As of February 2013**

<b>Type of pharmacy</b>	<b>Type of prescription<sup>a</sup></b>		
	<b>Formulary generic drugs<sup>b</sup></b>	<b>Formulary brand-name drugs<sup>b</sup></b>	<b>Non-formulary drugs</b>
Military treatment facility <sup>c</sup>	\$0	\$0	Not offered
TRICARE mail-order <sup>c</sup>	\$0	\$13	\$43
Network retail <sup>d</sup>	\$5	\$17	\$44
Non-network retail, <sup>d</sup> TRICARE Prime	50% copayment after the point-of-service deductible is met	50% copayment after the point-of-service deductible is met	50% copayment after the point-of-service deductible is met
Non-network retail, <sup>d</sup> TRICARE Extra and TRICARE Standard	\$17 or 20% of the total, whichever is greater, after the deductible is met	\$17 or 20% of the total, whichever is greater, after the deductible is met	\$44 or 20% of the total, whichever is greater, after the deductible is met

Source: GAO analysis of DOD information.

Note: Active duty servicemembers are not required to pay copayments or coinsurance. However, active duty servicemembers who fill prescriptions for covered drugs under the pharmacy benefit at non-network retail pharmacies are required to pay the total cost of the drug and then file a claim for reimbursement with the pharmacy services contractor.

<sup>a</sup>TRICARE offers formulary and non-formulary drugs. Formulary drugs are those on DOD's list of covered drugs. Non-formulary drugs can be obtained at formulary drug costs if medical necessity is established by the provider.

<sup>b</sup>A brand-name drug is a drug marketed under a proprietary, trademark-protected name. After any patent and market exclusivity for the brand-name drug expires, other drug companies may develop a generic equivalent—a similar drug that has the same active ingredient, strength, dosage form, route of administration, and intended use.

<sup>c</sup>Prescriptions filled at a military treatment facility or through the TRICARE mail-order pharmacy are limited to a 90-day supply.

<sup>d</sup>Prescriptions filled at a network or non-network retail pharmacy are limited to a 30-day supply.

<sup>12</sup>DOD is required to make all clinically appropriate drugs available to servicemembers and, with the exception of certain classes of drugs such as those for weight loss, DOD makes all Food and Drug Administration-approved drugs available. See 10 U.S.C. § 1074g; 32 C.F.R. §§ 199.4(g), 199.21(h)(3)(iii).

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## Management of TRICARE Pharmacy Services

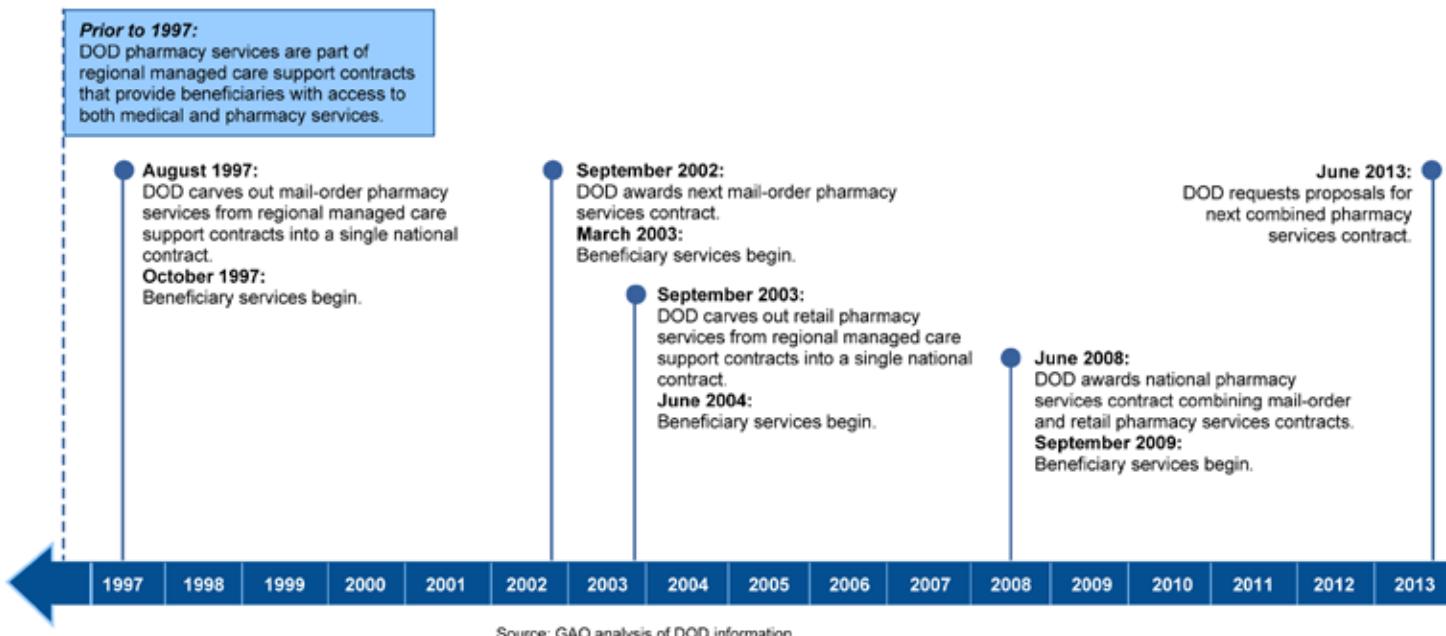
Prior to 1997, both retail and mail-order pharmacy services for TRICARE beneficiaries were included as part of the regional TRICARE managed care support contracts. In subsequent years, DOD carved out mail-order pharmacy services, followed by retail pharmacy services, as separate national contracts. Later, mail-order and retail pharmacy services were combined in a single national contract. (See fig. 1.) According to DOD, pharmacy services were carved out for three primary reasons: (1) to ensure a more consistent and efficient provision of the pharmacy benefit, (2) to leverage cost savings from federal direct-purchasing pricing,<sup>13</sup> and (3) to increase transparency in program utilization and cost data.<sup>14</sup> DOD continues to operate its military treatment facility pharmacies separately—they are not covered under the pharmacy services contract. In fiscal year 2012, military treatment facilities represented 40 percent of all TRICARE pharmacy utilization—measured as the number of days' supply of drugs dispensed. Although TRICARE pharmacy services are contracted separately from medical services, the pharmacy services contract requires the pharmacy services contractor and managed care support contractors to exchange information, such as data needed for care coordination.

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<sup>13</sup>Under 38 U.S.C. § 8126(a)(2), DOD has access to federally negotiated prices from drug manufacturers that are 24 percent lower than nonfederal average manufacturer prices when DOD is the direct purchaser of the drugs, as it is for the mail-order pharmacy and military treatment facility pharmacies. These federal pricing arrangements are available for the “Big Four” federal agencies that procure pharmaceuticals: the Department of Veterans Affairs, DOD, the U.S. Public Health Service (part of the Department of Health and Human Services), and the Coast Guard (part of the Department of Homeland Security). The NDAA for fiscal year 2008 required that federal pricing arrangements be applied to drugs dispensed at retail pharmacies as of January 28, 2008. See Pub. L. No. 110-181, § 703, 122 Stat. 3, 188 (codified at 10 U.S.C. § 1074g(f)).

<sup>14</sup>Department of Defense Military Health System Senior Oversight Committee, *Response to the Recommendations of the Task Force on the Future of Military Health Care*.

**Figure 1: Evolution of TRICARE Pharmacy Services Contract**



Source: GAO analysis of DOD information.

As the current pharmacy services contractor, Express Scripts serves as the pharmacy benefit manager, providing TRICARE beneficiaries with access to a network of more than 57,000 retail pharmacies, operating the TRICARE mail-order pharmacy, conducting claims processing, and reimbursing beneficiaries for claims. Express Scripts is the nation's largest pharmacy benefit manager, with \$93.9 billion in revenue in 2012.<sup>15</sup>

In recent years, DOD has taken steps to curb rising pharmacy costs.<sup>16</sup> One step has been to encourage beneficiaries to use the TRICARE mail-order pharmacy, which provides cost savings to DOD compared to retail

<sup>15</sup>Express Scripts, *2012 Annual Report*, (St. Louis, Mo.: 2013).

<sup>16</sup>We have previously reported on the need to reduce spending in DOD's pharmacy program. See GAO, *DOD Pharmacy Program: Continued Efforts Needed to Reduce Growth in Spending in Retail Pharmacies*, [GAO-08-327](#) (Washington, D.C.: April 2008).

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pharmacies.<sup>17</sup> In 2007, DOD established the Member Choice Center, operated by Express Scripts, to facilitate TRICARE beneficiaries' use of the mail-order pharmacy by providing assistance with transferring retail prescriptions to mail-order. In fiscal year 2012, according to DOD, the mail-order pharmacy represented 42 percent of all TRICARE pharmacy utilization outside of military treatment facility pharmacies, up from 32 percent in fiscal year 2011. In addition, in February 2013, in accordance with the NDAA for fiscal year 2013, DOD increased copayments for brand name and non-formulary drugs that are not filled at military treatment facility pharmacies by between 42 and 76 percent, depending on the pharmacy option used.<sup>18</sup> For example, the copayment for a 30-day supply of a non-formulary drug filled at a network retail pharmacy increased from \$25 to \$44.

DOD has also benefited from a legislative change and related court decision that resulted in reduced prescription drug costs for the department. The NDAA for fiscal year 2008 required that federal pricing arrangements that are available for drugs purchased by DOD, including those dispensed through military treatment facility pharmacies and the mail-order pharmacy, also be applied to drugs dispensed at TRICARE retail network pharmacies as of January 28, 2008.<sup>19</sup> In March 2009, drug manufacturers began providing refunds to DOD for most brand-name drugs dispensed after DOD issued final regulations,<sup>20</sup> accounting for a decline in DOD's retail pharmacy prescription drug costs in fiscal years 2010 and 2011. In January 2013, a federal court ruled that drug

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<sup>17</sup> Specifically, DOD purchases drugs directly from manufacturers through an intermediary known as a prime vendor for drugs dispensed through the mail-order pharmacy (and at military treatment facility pharmacies). Under DOD's contract with the prime vendor, the prime vendor provides drugs at a fixed percentage discount off of the lowest price otherwise available for each drug.

<sup>18</sup> See Pub. L. No. 112-239, § 712, 126 Stat. 1632, 1802 (2013) (codified at 10 U.S.C. § 1074g(a)(6)).

<sup>19</sup> See Pub. L. No. 110-181, § 703, 122 Stat. 3, 188 (codified at 10 U.S.C. § 1074g(f)). This act provides that with respect to any prescriptions filled on or after January 28, 2008, the TRICARE retail pharmacy program is to be treated as an element of DOD for purposes of procurement of drugs by federal agencies under 38 U.S.C. § 8126 to ensure that drugs paid for by DOD that are dispensed to TRICARE beneficiaries at retail pharmacies are subject to federal pricing arrangements.

<sup>20</sup> See 32 C.F.R. § 199.21(q); 74 Fed. Reg. 11,279 (Mar. 17, 2009); 75 Fed. Reg. 63,383 (Oct. 15, 2010).

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manufacturers are required to refund to DOD the difference between the federal pricing arrangements and the retail price paid for prescriptions filled dating back to the NDAA's enactment on January 28, 2008.<sup>21</sup> As of July 31, 2013, according to DOD, its total estimated savings from fiscal year 2009 through fiscal year 2013 were about \$6.53 billion as a result of these refunds.

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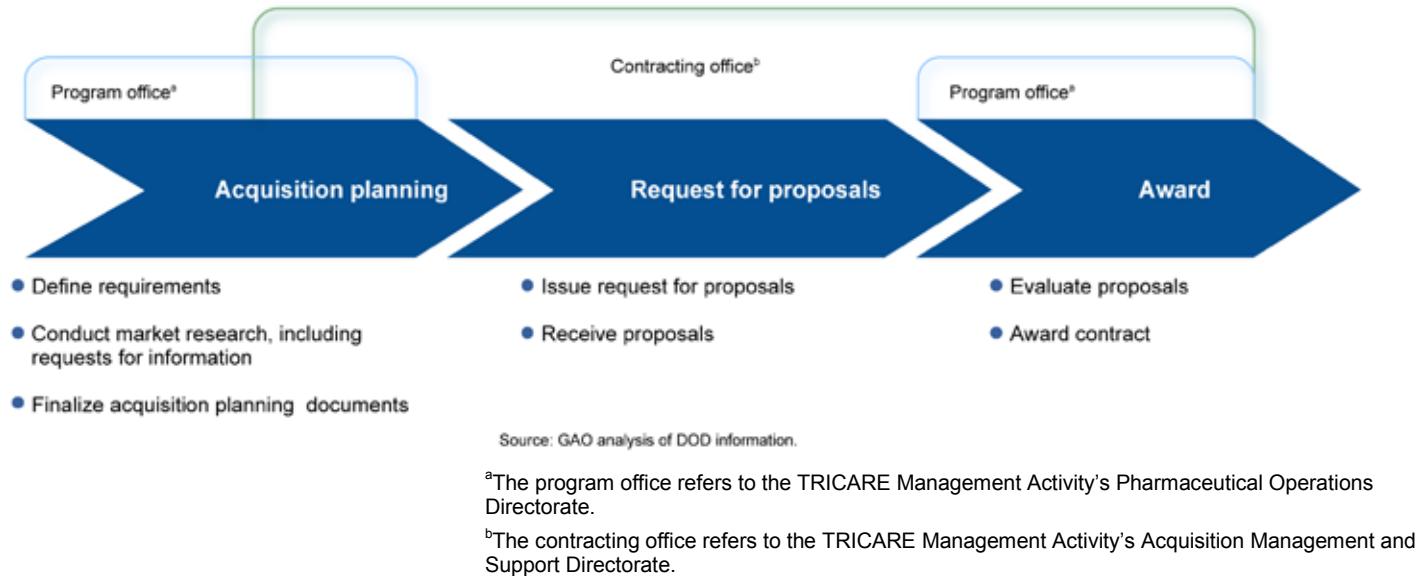
### **TRICARE's Pharmacy Services Contracting Process and Roles**

DOD's TRICARE Management Activity is responsible for overseeing the TRICARE program, including the pharmacy benefit. Within this office, the Pharmaceutical Operations Directorate (hereafter referred to as the program office) is responsible for managing the pharmacy benefit (including the contract to provide pharmacy services), and the Acquisition Management and Support Directorate (hereafter referred to as the contracting office) is responsible for managing all acquisitions for the TRICARE Management Activity. The two offices together manage the acquisition process for the pharmacy services contract. (See fig. 2.) The program office and the contracting office provide the clinical expertise and acquisition knowledge, respectively, for the acquisition planning, evaluation of proposals, and award of the pharmacy services contract.

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<sup>21</sup>Coalition for Common Sense in Gov't Procurement v. United States, 707 F.3d 311 (D.C. Cir. 2013).

**Figure 2: Selected Roles and Activities in the Acquisition Process for DOD's Pharmacy Services Contract**



The acquisition process for DOD's pharmacy services contract includes three main phases: (1) acquisition planning, (2) RFP, and (3) award.<sup>22</sup>

**Acquisition planning.** In the acquisition planning phase, the program office, led by the program manager, is primarily responsible for defining TRICARE's contract requirements—the work to be performed by the contractor—and developing a plan to meet those requirements. The program office also receives guidance and assistance from the contracting office in the development and preparation of key acquisition documents and in the market research process. The market research process can involve the development and use of several information-gathering tools, including requests for information (RFI), which are publicly released documents that allow the government to obtain feedback from industry on various acquisition elements such as the terms

<sup>22</sup>There are federal- and department-level requirements that govern the process for each phase of the acquisition process. The regulatory policies for DOD acquisitions are outlined in the FAR and the DFARS. In addition, DOD and its TRICARE Management Activity issue other manuals, policies, and guidance documents to assist in the acquisition process.

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and conditions of the contract. RFIs are also a means by which the government can identify potential offerors and determine whether the industry can meet its needs. In addition, we have previously reported that sound acquisition planning includes an assessment of lessons learned to identify improvements.<sup>23</sup>

Towards the end of this phase, officials in the program and contracting offices work together to revise and refine key acquisition planning documents.

**RFP.** In the RFP phase, the contracting officer—the official in the contracting office who has the authority to enter into, administer, modify, and terminate contracts—issues the RFP,<sup>24</sup> and receives the proposals.

**Award.** In the award phase, the program and contracting offices are responsible for evaluating proposals and awarding a contract to the offeror representing the best value to the government based on a combination of technical and cost factors.

To monitor the contractor's performance under the contract after award, the contracting officer officially designates a program office official as the contracting officer's representative (COR), who acts as the liaison between the contracting officer and the contractor and is responsible for the day-to-day monitoring of contractor activities to ensure that the services are delivered in accordance with the contract's performance standards.<sup>25</sup> The draft monitoring plan for the upcoming pharmacy services contract includes 30 standards—related to timeliness of claims processing, retail network access, and beneficiary satisfaction, among other things—against which the contractor's performance will be measured.

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<sup>23</sup>[GAO-11-672](#).

<sup>24</sup>RFPs include a description of the contract requirements, the anticipated terms and conditions that will be contained in the contract, the required information that the prospective offerors must include in their proposal, and the factors that will be used to evaluate proposals.

<sup>25</sup>As of July 2013, the pharmacy services contract had two CORs, one to monitor clinical issues and one to monitor operational and systems issues.

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DOD has department-wide acquisition training and experience requirements for all officials who award and administer DOD contracts, including the pharmacy services contract, as required by law.<sup>26</sup> Training is primarily provided through the Defense Acquisition University,<sup>27</sup> and is designed to provide a foundation of acquisition knowledge, but is not targeted to specific contracts or contract types. In addition, all CORs must meet training and experience requirements specified in DOD's *Standard for Certification of Contracting Officer's Representatives (COR) for Service Acquisitions* issued in March 2010.<sup>28</sup> See appendix I for more information on the certification standards for and experience of officials who award and administer the pharmacy services contract.

In September 2010, DOD issued guidance to help improve defense acquisition through its Better Buying Power Initiative.<sup>29</sup> DOD's Better Buying Power Initiative encompasses a set of acquisition principles designed to achieve greater efficiencies through affordability, cost control, elimination of unproductive processes and bureaucracy, and promotion of competition; it provides guidance to acquisition officials on how to implement these principles. The principles are also designed to provide incentives to DOD contractors for productivity and innovation in industry and government.

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<sup>26</sup>Defense Acquisition Workforce Improvement Act, Pub. L. No. 101-510, tit. XII, §§ 1201-1211, 104 Stat. 1485, 1638 (1990) (codified at 10 U.S.C. ch. 87).

<sup>27</sup>The Defense Acquisition Workforce Improvement Act established the Defense Acquisition University as the primary provider of acquisition training for DOD and the military departments. See 10 U.S.C. § 1746.

<sup>28</sup>This standard defines DOD-wide minimum COR competencies, experience, and training according to the complexity of requirements and contract performance risk.

<sup>29</sup>DOD updated its Better Buying Power Initiative guidance in April 2013.

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## DOD Used Various Methods to Identify Changes to Contract Requirements for the Upcoming and Current Pharmacy Services Contracts

### DOD Used Market Research to Align the Requirements for Its Upcoming Pharmacy Services Contract with Industry Best Practices and Promote Competition

DOD used market research to align the requirements for the upcoming pharmacy services contract with industry best practices and promote competition. DOD also identified changes to the requirements for the upcoming and current contracts in response to changes in legislation, efforts to improve service delivery, and contractor performance.

DOD solicited information from industry during its acquisition planning for the upcoming pharmacy services contract through the required market research process,<sup>30</sup> including issuing RFIs and a draft RFP for industry comment, to identify changes to requirements for its pharmacy services contract. Specifically, DOD used market research to align the requirements for the upcoming contract with industry best practices and promote competition.

#### **Align contract requirements with industry best practices.**

DOD issued five RFIs from 2010 through 2012 related to the upcoming contract. RFIs are one of several market research methods available to federal agencies.<sup>31</sup> Although DOD is not required to use them, RFIs are considered a best practice for service acquisitions in the federal government.<sup>32</sup> The RFIs provided DOD with the opportunity to assess the capability of potential offerors to provide services that DOD may incorporate in the upcoming pharmacy services contract. In many of the RFIs,

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<sup>30</sup>See FAR § 10.001(a)(2) and DFARS § 210.001(a).

<sup>31</sup>See FAR § 10.002(b)(2).

<sup>32</sup>See, for example, Office of Management and Budget, Office of Federal Procurement Policy, “*Myth-Busting*”: *Addressing Misconceptions to Improve Communication with Industry During the Acquisition Process*, Memorandum for Chief Acquisition Officers, Senior Procurement Representatives, Chief Information Officers (Washington, D.C.: Feb. 2, 2011) and Office of Management and Budget, Office of Federal Procurement Policy, “*Myth-Busting 2*”: *Addressing Misconceptions and Further Improving Communication During the Acquisition Process*, Memorandum for Chief Acquisition Officers, Senior Procurement Representatives, Chief Information Officers (Washington, D.C.: May 7, 2012).

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DOD asked questions about specific market trends so that it could determine if changes were needed to the upcoming contract requirements to help align them with industry best practices. For example, DOD issued one RFI in November 2010 that asked about establishing a mechanism that would allow for centralized distribution of specialty pharmaceuticals and preserve DOD's federal pricing arrangements. Specialty pharmaceuticals—high-cost injectable, infused, oral, or inhaled drugs that are generally more complex to distribute, administer, and monitor than traditional drugs—are becoming a growing cost driver for pharmacy services. According to DOD officials, the RFI responses received from industry generally reinforced their view that the RFP should define any specialty pharmacy owned or sub-contracted by the contractor as a DOD specialty mail-order outlet, which would subject it to the same federal pricing arrangements as the mail-order pharmacy.

**Promote competition.** DOD has also used the RFI process to obtain information on promoting competition. DOD recognized that a limited number of potential offerors may have the capability to handle the pharmacy services contract given the recent consolidation in the pharmacy benefit management market<sup>33</sup> and the large size of the TRICARE beneficiary population. DOD contracting officials told us that, in part because of the department's Better Buying Power Initiative to improve acquisition practices, they have a strong focus on maintaining a competitive contracting environment for the pharmacy services contract, thereby increasing the use of market research early in the acquisition planning process. For example, DOD's December 2011 RFI asked for industry perspectives on the length of the contract period. DOD was interested in learning whether a longer contract period would promote competition. DOD officials told us that the responses they received confirmed that potential offerors would prefer a longer contract period because it would allow a non-incumbent more time to recover any capital investment made as part of implementing the contract. The RFP for the upcoming

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<sup>33</sup>One of the largest recent mergers was Express Scripts' acquisition of Medco Healthcare Solutions in 2012. As a result, the nation's four largest pharmacy benefit managers (Express Scripts, CVS Caremark, OptumRx, and Catamaran) are projected to represent over 70 percent of the market in 2013.

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contract includes a contract period of 1 base year and 7 option years.<sup>34</sup> DOD also used the RFI process to confirm that there were a sufficient number of potential offerors to ensure full and open competition for the pharmacy services contract. DOD officials told us that they found there were at least six potential offerors, which gave them confidence that there would be adequate competition.<sup>35</sup>

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## DOD Identified Changes to Requirements for its Upcoming and Current Pharmacy Services Contracts in Response to Legislation, Efforts to Improve Service Delivery, and Contractor Performance

Since the start of the current pharmacy services contract in 2009, DOD has identified changes to the contract requirements in response to legislative changes to the pharmacy benefit, efforts to improve service delivery to beneficiaries, and improvements identified through monitoring of the current contractor's performance. In each instance, DOD officials needed to determine whether to make the change for the upcoming contract, or whether to make the change via a modification to the current contract.<sup>36</sup> According to DOD officials, there were over 300 modifications to the current pharmacy services contract; 23 of these were changes to the work to be done by the contractor.<sup>37</sup> DOD officials told us that it is not possible to build a level of flexibility into the contract to accommodate or anticipate all potential changes (and thus avoid modifications to the contract), because doing so would make it difficult for offerors to determine pricing in their proposals.

**Legislative changes to the pharmacy benefit.** Legislative changes have been one key driver of DOD's revisions to its pharmacy services contract requirements. For example, one legislative change required DOD to implement the TRICARE

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<sup>34</sup>10 U.S.C. § 2304a(f) and FAR § 217.204(e) establish a 5-year limit on the contract period of service contracts. The contract period may be subsequently extended for one or more option periods but may not exceed 10 years unless the head of the agency determines in writing that exceptional circumstances require a longer contract period.

<sup>35</sup>See FAR § 15.403-1(c)(1).

<sup>36</sup>In making this determination, DOD officials consider several issues, including the time frame for implementing the change and the associated costs.

<sup>37</sup>According to DOD officials, other reasons for modifications to the contract included updates to the TRICARE manuals and administrative changes to contract wording.

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Young Adult program,<sup>38</sup> which resulted in DOD adding a requirement for the contractor to extend pharmacy services to eligible military dependents through the age of 26. This change was made as a modification under the current contract. Another legislative change that necessitated changes to the contract requirements was the increase in beneficiary copayments for drugs obtained through mail-order or retail pharmacies, enacted as part of the NDAA for fiscal year 2013, which DOD changed through a modification to the current contract.<sup>39</sup> A third legislative change to the pharmacy benefit was the mail-order pilot for maintenance drugs for TRICARE for Life beneficiaries.<sup>40</sup> DOD officials incorporated this change in the requirements for the upcoming pharmacy services contract, as outlined in the RFP.

**Efforts to improve service delivery.** DOD has also updated contract requirements to improve service delivery to beneficiaries under the pharmacy services contract. DOD initiated a modification to the current contract to require the contractor to provide online coordination of benefits for beneficiaries with health care coverage from multiple insurers. Specifically, the contractor is required to ensure that pharmacy data systems include information on government and other health insurance coverage to facilitate coverage and payment determinations. According to DOD officials, this change is consistent with the updated national

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<sup>38</sup>The TRICARE Young Adult program was implemented in 2011. The NDAA for fiscal year 2011 required that TRICARE coverage be extended to unmarried dependents of TRICARE beneficiaries up to age 26 who are not eligible for employer-sponsored health insurance, which is similar to a provision in the Patient Protection and Affordable Care Act that directed certain private health insurance plans to extend coverage to dependent children up to age 26. See Pub. L. No. 111-383, § 702, 124 Stat. 4137, 4244-45 (2011) (codified at 10 U.S.C. § 1110b).

<sup>39</sup>In accordance with the NDAA for fiscal year 2013, copayment amounts were increased for prescriptions for brand-name and non-formulary drugs filled through the mail-order pharmacy or through retail pharmacies beginning in February 2013. See Pub. L. No. 112-239, § 712, 126 Stat. 1632, 1802 (2013) (codified at 10 U.S.C. § 1074g(a)(6)).

<sup>40</sup>The NDAA for fiscal year 2013 generally requires that, under the pilot, TRICARE for Life beneficiaries receive refills of all maintenance drugs through the mail-order pharmacy or military treatment facility pharmacies for at least 1 year, after which time they may opt out of the pilot. See Pub. L. No. 112-239, § 716, 126 Stat. 1632, 1804 (2013). Maintenance drugs are prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Examples of chronic conditions that may require maintenance drugs are high blood pressure, high cholesterol, and diabetes.

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telecommunication standard from the National Council for Prescription Drug Programs, which provides a uniform format for electronic claims processing.<sup>41</sup> According to DOD officials, this change to the contract requirements eliminates the need for beneficiaries to file paper claims when TRICARE is the secondary payer, simplifying the process for beneficiaries and reducing costs for DOD. Another modification to the current contract to improve service delivery was to require the contractor to provide vaccines through its network of retail pharmacies. According to DOD officials, this modification was made to allow beneficiaries to access vaccines through every possible venue, driven by the 2010 H1N1 influenza pandemic.

**Contractor performance.** DOD officials told us that improvements identified through the monitoring of contractor performance have also led to changes in contract requirements. Through the CORs' monitoring of the contractor's performance against the standards specified in the contract, the CORs may determine that a particular standard is not helping to achieve the performance desired or is unnecessarily restrictive. For example, DOD officials told us that in the current contract, they had a three-tiered standard for paper claims processing (e.g., 95 percent of paper claims processed within 10 days, 99 percent within 20 days, and 100 percent within 30 days). Through monitoring the contractor's performance, the CORs determined that there was a negligible difference between the middle and high tiers, and holding the contractor to this performance standard was not beneficial. The requirements for the upcoming contract as described in the RFP only include two tiers—95 percent of claims processed within 14 calendar days, and 100 percent within 28 calendar days.

When making changes to contract requirements, DOD officials told us they try to ensure that the requirements are not overly prescriptive, but rather outcome-oriented and performance-based. For example, DOD officials told us that they allowed the pharmacy and managed care support contractors to innovate and apply industry best practices

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<sup>41</sup>The National Council for Prescription Drug Programs is a nonprofit standards development organization representing various sectors of the pharmacy services industry.

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regarding coverage and coordination of home infusion services.<sup>42</sup> According to DOD officials, the contract requirements regarding home infusion are focused on the desired outcome—providing coordination of care for beneficiaries needing these services with the physician as the key decision maker—and DOD officials facilitated meetings between the pharmacy contractor and managed care support contractors to determine the details of how to provide the services.<sup>43</sup> This approach is consistent with DOD's Better Buying Power principles that emphasize the importance of well-defined contract requirements and acquisition officials' understanding of cost-performance trade-offs. This approach also addresses a concern we have previously identified regarding overly prescriptive contract requirements in TRICARE contracts; specifically, in our previous work on the managed care support contracts, we reported that DOD's prescriptive requirements limited innovation and competition among contractors.<sup>44</sup>

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<sup>42</sup>When home infusion was added as a new covered service under TRICARE, DOD officials modified the pharmacy services contract to include it, effective January 2012. Home infusion requires coordination among providers of drugs, equipment, and skilled nursing care, as needed. See GAO, *Home Infusion Therapy: Differences between Medicare and Private Insurers' Coverage*, GAO-10-426 (Washington D.C.: June 7, 2010), for information about Medicare's and private insurers' coverage of home infusion services.

<sup>43</sup>Additionally, according to DOD, coordination between the managed care support contractors and the pharmacy contractor regarding home infusion is needed because the costs for drugs are far greater when obtained under the medical benefit, allowing for significant cost savings to be realized when drugs are obtained under the pharmacy benefit.

<sup>44</sup>See GAO, *Defense Health Care: Lessons Learned from TRICARE Contracts and Implications for the Future*, GAO-01-742T (Washington, D.C.: May 17, 2001).

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## DOD Has Not Conducted an Assessment of Its Pharmacy Services Contract that Includes an Evaluation of the Costs and Benefits of Alternative Structures

Since retail pharmacy services were carved out about 10 years ago, DOD has not conducted an assessment of the appropriateness of its current pharmacy services contract structure that includes an evaluation of the costs and benefits of alternative structures. Alternative structures can include a carve-in of all pharmacy services into the managed care support contracts, or a structure that carves in a component of pharmacy services, such as the mail-order pharmacy, while maintaining a carve-out structure for other components. DOD officials told us they believe that DOD's current pharmacy services contract structure continues to be appropriate, as it affords more control over pharmacy data and allows for more detailed data analyses and increased transparency about costs. DOD's continued use of a carve-out contract structure for pharmacy services is consistent with findings from research and perspectives we heard from industry group officials—that larger employers are more likely to carve out pharmacy services to better leverage the economies of scale and cost savings a stand-alone pharmacy benefit manager can achieve.<sup>45</sup> These arrangements may also provide more detailed information on drug utilization that can be helpful in managing drug formularies and their associated costs.

In its December 2007 report, the Task Force on the Future of Military Health Care recommended examining an alternative structure for the pharmacy services contract.<sup>46</sup> In addition to other aspects of DOD's health care system, the task force reviewed DOD's pharmacy benefit program, recommending that DOD pilot a carve-in pharmacy contract structure within one of the TRICARE regions with a goal of achieving better financial and health outcomes as a result of having more integrated pharmacy and medical services. The managed care support contractors we spoke with expressed similar concerns. However, DOD did not agree with the task force's recommendation. In its response, DOD assessed the

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<sup>45</sup>See Mercer Human Resource Consulting, *Prescription Drug Benefit Plans: A Buyer's Guide* (Oakland, CA: California HealthCare Foundation, Jan. 2003); and Mercer, *National Survey of Employer Sponsored Health Plans 2011*, (New York, N.Y.: Marsh and McLennan Companies, 2011).

<sup>46</sup>See Department of Defense, *Final Report of the Task Force on the Future of Military Health Care*. The NDAA for Fiscal Year 2007 directed DOD to establish a task force to assess health care services provided to members of the military, retirees, and their families, and to make recommendations for sustaining those services. See Pub. L. No. 109-364, § 711, 120 Stat. 2284-87 (2006).

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benefits of the current structure and affirmed the department's commitment to this structure.<sup>47</sup>

**Potential cost savings.** In its response to the task force report, DOD did not concur with the recommendation to pilot a carve-in pharmacy contract structure, in part because of the cost savings achieved through the carve-out. Specifically, DOD stated that the carve-out arrangement is compatible with accessing federal pricing arrangements and other discounts available for direct purchases. DOD stated in its response that, under a carve-in arrangement, even on a pilot basis, it would lose access to discounts available for direct purchases, including some portion of the \$400 million in annual discounts available for drugs dispensed at retail pharmacies under the NDAA for fiscal year 2008. DOD officials told us that this loss would result from the managed care support contractor being the purchaser of the drugs, rather than DOD. DOD also stated that it would possibly lose access to the volume discounts obtained for drugs purchased for the mail-order pharmacy and military treatment facility pharmacies under a carve-in structure. DOD officials told us that these disadvantages of a carve-in structure remain the same today. Additionally, during this review, DOD noted that dividing the TRICARE beneficiary population among contractors under a carve-in would dilute the leverage a single pharmacy benefit manager would have in the market. For example, DOD would lose economies of scale for claims processing services provided by the pharmacy contractor, resulting in increased costs.

However, research studies have found, and officials from TRICARE's managed care support contractors told us, that a contract structure with integrated medical and pharmacy services could result in cost savings for DOD. For example, one recent study found that employers with carve-in health plans had 3.8 percent lower total medical care costs compared to employers

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<sup>47</sup>Department of Defense Military Health System Senior Oversight Committee, *Response to the Recommendations of the Task Force on the Future of Military Health Care*.

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with pharmacy services carved out.<sup>48</sup> The researchers attributed the cost difference, in part, to increased coordination of care for the carve-in plans, leading to fewer adverse events for patients, resulting in fewer inpatient admissions; they reported that plans with a carve-out arrangement had 7 percent higher inpatient admissions. Similarly, representatives from one managed care support contractor we spoke with stated they thought they could achieve similar cost savings to what DOD currently has through its federal pricing arrangements by using integrated medical and pharmacy services as a means of reducing costs in a carve-in arrangement. Being able to analyze integrated, in-house medical and pharmacy data may help health plans to lower costs by identifying high-cost beneficiaries, including those with chronic conditions such as asthma and diabetes, and targeting timely and cost-effective interventions for this population.<sup>49</sup>

**Potential health benefits from data integration.** In recommending that DOD pilot a carve-in pharmacy contract structure, one of the task force's goals was to improve health outcomes as a result of integrated medical and pharmacy services. DOD noted in its task force response that it could achieve this goal under the current carve-out contract structure by including requirements in the pharmacy services contract and managed care support contracts requiring data sharing between the contractors.

While the current contract requires the pharmacy and managed care support contractors to exchange data for care coordination, current TRICARE managed care support contractors told us there continue to be challenges with data sharing to facilitate disease

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<sup>48</sup>See HealthPartners, *HealthPartners Pharmacy Integration Study: Demonstrating the value of medical and pharmacy benefit integration*, (Bloomington, Minn.: HealthPartners, Inc., October 2010); and E.J. Culley, L.C. Williams, and L. Thomas, "Pharmacy Benefit Carve-In: The Right Prescription for Cost Savings," *Benefits & Compensation Digest*, vol. 47, no. 2 (2010).

<sup>49</sup>See Culley, Williams, and Thomas, "Pharmacy Benefit Carve-In," 24; and T. Dickman, "Carve-in Strategy Adds Context to Integrated Pharmacy Investment," *Managed Healthcare Executive*, vol. 13, no. 7 (2003).

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management.<sup>50</sup> Contractors expressed similar concerns about sharing medical and pharmacy data as part of our previous work related to DOD's managed care support contracts.<sup>51</sup> Additionally, during this review, officials from one of the managed care support contractors told us that they continue to find it challenging to generate data that provide a holistic view of beneficiaries when medical and pharmacy data remain separate. Representatives from another managed care support contractor told us that their disease management staff faced challenges in analyzing pharmacy data for groups of patients they were managing. They also told us that if these staff had more complete and real-time access to pharmacy data, as they would under a carve-in structure, they could be more proactive in assisting DOD's efforts to identify patients who should participate in disease management programs. Additionally, researchers have found that disease management interventions may be challenging to conduct in a carve-out arrangement due to the lack of fully integrated medical and pharmacy data.<sup>52</sup>

According to DOD officials, any changes to the current contract structure would result in less efficient and inconsistent pharmacy service delivery across the three TRICARE regions, as officials observed when the retail pharmacy benefit was part of the managed care support contracts. One of DOD's reasons for the initial carve-out was a concern that pharmacy services were not being consistently implemented across the TRICARE regions. For example, DOD officials told us that two health plans in different TRICARE regions were able to have different preferred drugs within the same therapeutic class, and while both drugs may be included on DOD's formulary, beneficiaries in different parts of the country were not being consistently provided with the same drug. In addition, according to DOD, beneficiaries were dissatisfied with a benefit that was not portable across TRICARE regions—specifically, retail pharmacy networks

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<sup>50</sup>Disease management involves providing coordinated health care interventions and communications to patients who have chronic conditions, such as diabetes or asthma, where patients' self-care efforts can affect their health outcomes.

<sup>51</sup>GAO, *Defense Health Care: Implementation Issues for New TRICARE Contracts and Regional Structure*, GAO-05-773 (Washington, D.C.: July 2005).

<sup>52</sup>See Culley, Williams, and Thomas, "Pharmacy Benefit Carve-In," 24; and Dickman, "Carve-in Strategy," 31.

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differed by region, so beneficiaries who moved from one TRICARE region to another would have to change retail pharmacy networks. With one national pharmacy services contract, DOD officials said they can ensure that the formulary is implemented consistently and that beneficiaries have access to the same retail pharmacy network across the TRICARE regions.

Since the current pharmacy services contract structure was implemented almost 10 years ago, DOD has not incorporated an assessment of the contract structure that includes an evaluation of alternative structures into its acquisition planning activities. DOD officials told us that they consider their task force response to be an assessment of the current contract structure. While the response included a justification for the current structure, it did not include an evaluation of the potential costs and benefits of alternative structures, such as carving in all or part of the pharmacy benefit. In addition, the acquisition plan for the upcoming contract described two alternative carve-out configurations (separate contracts for the mail-order and retail pharmacies and a government-owned facility to house drugs for the mail-order pharmacy contract). However, the plan similarly did not include an evaluation of the potential costs and benefits of these options, nor did the plan include an evaluation of any carve-in alternatives. DOD officials told us there are no current plans to conduct such an evaluation as part of the department's acquisition planning efforts.

DOD officials also told us that they continue to believe the current structure is appropriate because the current carve-out structure provides high beneficiary satisfaction and is achieving DOD's original objectives, namely consistent provision of benefits, access to federal pricing arrangements, and transparency of pharmacy utilization and cost data. Further, officials told us that the current carve-out structure is more efficient to administer with one pharmacy services contractor than the previous carve-in structure that involved multiple managed care support contractors.

While DOD officials believe the current structure is appropriate, there have been significant changes in the pharmacy benefit management market in the past decade. These changes include mergers, as well as companies offering new services that may change the services and options available to DOD. For example, representatives from one managed care support contractor we spoke with told us that they can offer different services to DOD today than they were able to offer when pharmacy services were part of the managed care support contracts.

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While the contractor had previously sub-contracted with a separate pharmacy benefit manager to provide pharmacy services under its managed care support contract, this contractor's parent company now provides in-house pharmacy benefit management services for its commercial clients. Additionally, according to the parent company of another managed care support contractor, its recent decision to bring pharmacy benefit management services in-house will enhance its ability to manage total health care costs and improve health outcomes for clients who carve in pharmacy services.

As we have previously reported, sound acquisition planning includes an assessment of lessons learned to identify improvements.<sup>53</sup> The time necessary for such activities can vary greatly, depending on the complexity of the contract. We have also reported that a comparative evaluation of the costs and benefits of alternatives can provide an evidence-based rationale for why an agency has chosen a particular alternative (such as a decision to maintain or alter the current pharmacy services contract structure).<sup>54</sup> We have reported that such an evaluation would consider possible alternatives and should not be developed solely to support a predetermined solution.

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## Conclusions

With each new pharmacy services contract, DOD officials have the opportunity to conduct acquisition planning activities that help determine whether the contract—and its current structure—continues to meet the department's needs, including providing the best value and services to the government and beneficiaries. These activities can include changing requirements as necessary, learning about current market trends, and incorporating new information and lessons learned. Acquisition planning can also incorporate an assessment of the pharmacy services contract structure that includes an evaluation of the potential costs and benefits of alternative contract structures. Incorporating such an evaluation into the acquisition planning for each new pharmacy services contract can provide DOD with an evidence-based rationale for why maintaining or changing the current structure is warranted. Without such an evaluation, DOD cannot effectively demonstrate to Congress and stakeholders that it has

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<sup>53</sup> GAO-11-672.

<sup>54</sup> GAO-09-3SP.

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chosen the most appropriate contract structure, in terms of costs to the government and services for beneficiaries.

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## Recommendations for Executive Action

To provide decision makers with more complete information on the continued appropriateness of the current pharmacy services contract structure, and to ensure the best value and services to the government and beneficiaries, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to take the following two actions:

- conduct an evaluation of the potential costs and benefits of alternative contract structures for the TRICARE pharmacy services contract; and
- incorporate such an evaluation into acquisition planning.

## Agency Comments and Our Evaluation

We provided a draft of this report to DOD for comment. DOD generally concurred with our findings and conclusions and concurred with our recommendations. DOD also commented that based on past experience with alternative contract structures, it is confident that the current contract structure is the most cost efficient and beneficial.

In response to our recommendation that DOD conduct an evaluation of the potential costs and benefits of alternative contract structures for the TRICARE pharmacy services contract, DOD commented that there is a lack of data to support inferences that a carve-in arrangement would result in cost savings to the government, and noted that the full development of two separate RFPs would be necessary to provide a valid cost comparison. While detailed cost estimates can be a useful tool for DOD, they are not the only means of evaluating alternative structures for the pharmacy services contract. For example, as we noted in our report, DOD has previously used RFIs to obtain information from industry to inform its decisions about the pharmacy services contract, and this process also may be helpful in identifying costs and benefits of alternative contract structures.

In response to our recommendation that DOD incorporate such an evaluation into acquisition planning, DOD commented that it included an evaluation of its past contract experience into acquisition planning for the upcoming pharmacy services contract. However, as noted in our report, the acquisition plan for the upcoming contract did not include an evaluation of the potential costs and benefits of alternative contract

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structures, and DOD did not directly address how it would include such an evaluation in its acquisition planning activities. We continue to emphasize the importance of having an evidence-based rationale for why maintaining or changing the current structure is warranted. With each new pharmacy services contract, DOD officials have the opportunity to determine whether the contract continues to meet the department's needs, including providing the best value to the government and services to beneficiaries.

In addition, DOD stated in its comments that our report did not address its direct-care system and noted that carving pharmacy services back into the managed care support contracts would fragment the pharmacy benefit and undermine its goal of integrating all pharmacy points of service. Our review was focused on DOD's purchased-care system for providing pharmacy services, although we did provide context about the direct-care system as appropriate. Furthermore, we did not recommend any specific structure for DOD's pharmacy services contract, but rather that DOD evaluate the costs and benefits of alternative structures such that it can have an evidence-based rationale for its decisions.

DOD's comments are reprinted in appendix II. DOD also provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to appropriate congressional committees; the Secretary of Defense; the Assistant Secretary of Defense (Health Affairs); and other interested parties. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at [draperd@gao.gov](mailto:draperd@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



Debra A. Draper  
Director, Health Care

# Appendix I: Certification Standards for and Experience of TRICARE Pharmacy Services Contract Officials

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Department of Defense (DOD) officials who award and administer the TRICARE pharmacy services contract are required to meet relevant certification standards applicable to all DOD acquisition officials and, according to DOD officials, some of these officials also have pharmacy-specific experience.<sup>1</sup> The training and related education and experience requirements are tailored to different levels of authority and, due to the size and complexity of the pharmacy services contract, the contracting officer and program manager for the pharmacy services contract are required to be certified at the highest levels, which require the most training and experience.<sup>2</sup> In addition, all contracting officer's representatives (COR) must meet specific training and experience requirements based on the complexity and risk of the contracts they will be working with,<sup>3</sup> and the two CORs for the pharmacy services contract are also required to meet the highest COR certification level. For example, the CORs for the pharmacy services contract must complete at least 16 hours of COR-specific continuing education every 3 years, which is twice the amount required for low-risk, fixed-price contracts. DOD's department-wide acquisition training is primarily provided through the Defense Acquisition University.<sup>4</sup> Training is designed to provide a foundation of acquisition knowledge but is not targeted to specific contracts or contract types. Beyond DOD's required training, the

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<sup>1</sup>In our work, we did not determine whether DOD officials who award and administer the TRICARE pharmacy services contract complied with certification standards, nor did we verify information provided regarding these officials' pharmacy-specific experience. In May 2013, the DOD Inspector General reported that selected acquisition staff within the TRICARE Management Activity did not have required certifications, accurate position descriptions, or proper training, and recommended that the TRICARE Management Activity improve oversight of these issues. TRICARE officials agreed with the recommendations and stated that corrective actions would be implemented within a year. See Department of Defense, Inspector General, *TRICARE Management Activity Needs to Improve Oversight of Acquisition Workforce*, DODIG-2013-078 (Alexandria, Va.: May 1, 2013). Although, according to a DOD Inspector General official, pharmacy services contract staff were not included in the scope of the audit, the recommendations apply to all TRICARE Management Activity acquisition staff, which would include officials who award and administer the pharmacy services contract.

<sup>2</sup>See Defense Acquisition Workforce Improvement Act, Pub. L. No. 101-510, tit. XII, §§ 1201-1211. 104 Stat. 1485, 1638 (1990) (codified at 10 U.S.C. ch. 87).

<sup>3</sup>Department of Defense, *DOD Standard for Certification of Contracting Officer's Representatives (COR) for Service Acquisitions*, (Washington, D.C.: 2010).

<sup>4</sup>The Defense Acquisition Workforce Improvement Act established the Defense Acquisition University as the primary provider of acquisition training for DOD and the military departments. See 10 U.S.C. § 1746.

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**Appendix I: Certification Standards for and Experience of TRICARE Pharmacy Services Contract Officials**

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contracting officer, program manager, and CORs also have specialized experience in pharmacy and related issues. See table 2 for the specific certification standards for and pharmacy-specific experience of the officials responsible for awarding or administering the pharmacy services contract.

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**Table 2: Acquisition Training, Education, and Experience Certification Standards and Pharmacy-Specific Experience of Officials Who Award or Administer the TRICARE Pharmacy Services Contract**

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Official	Certification standards		
	Acquisition training and education <sup>a</sup>	Acquisition experience	Pharmacy-specific experience held by officials as of May 2013
Contracting officer	Minimum four core courses; Bachelor's degree and 24 semester hours of relevant coursework  Four additional courses preferred for officials holding this position; Master's degree preferred  80 hours of continuing education required every 2 years	4 years acquisition experience  Additional 4 years acquisition experience preferred	The contracting officer also has on-the-job experience with TRICARE's pharmacy and managed care support contracts.
Program manager	Minimum six core courses; no education standard  Eight additional courses preferred for officials holding this position; Master's degree in relevant field preferred	2 years acquisition experience, including 1 year in program management  Additional 2 years acquisition experience preferred	The program manager is a registered pharmacist.
Contracting officer's representative (COR)	8 hours of coursework required  At least 16 hours of COR-specific continuing education required every 3 years	12 months of DOD experience	The two CORs for the pharmacy contract together have experience with clinical and operations/systems aspects of the pharmacy program. The current clinical COR holds a doctoral degree in pharmacy. The current operations COR holds a bachelors degree in Information Technology and has pharmacy experience from prior military service.

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Source: GAO analysis of DOD information.

Note: In our work, we did not determine whether DOD officials complied with certification standards, nor did we verify information provided regarding pharmacy-specific experience.

<sup>a</sup>Training is primarily provided through the Defense Acquisition University.

# Appendix II: Comments from the Department of Defense

  
**THE ASSISTANT SECRETARY OF DEFENSE**  
1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200  
**SEP 13 2013**

**HEALTH AFFAIRS**

Ms. Deborah Draper  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, N.W.  
Washington, DC 20548

Dear Ms. Draper:

This letter is the Department of Defense's (DoD) response to the Government Accountability Office (GAO) draft report, GAO-13-808 entitled, "DEFENSE HEALTH CARE: Evaluation of TRICARE Pharmacy Service Contract Structure is Warranted," dated August 20, 2013, (GAO Code 291104). Thank you for the opportunity to review and comment on the draft report.

Overall, I generally concur with the draft report's findings and conclusion. I will take this opportunity to offer remarks in addition to the specific comments regarding Recommendations and Technical Comments on the following pages. I believe these comments will improve the accuracy and value of the final report by preventing misinterpretation of the findings and by mitigating conclusions that could be drawn out of context.

A key consideration that was not mentioned is that DoD's pharmacy program consists of direct care in addition to purchased care. We have a very clear operational goal of trying to integrate all the pharmacy points of service. Fragmenting the pharmacy benefit by placing it under multiple contractors for retail and mail, while maintaining direct care under government management, undermines the operational goal that has taken years to achieve. Direct care remains our most cost-effective point of service. Attempting to maximize the direct care pharmacy benefit requires a fully integrated management and delivery structure. Anything that detracts from full integration and our ability to maximize use of direct care is counter-intuitive.

My points of contact on this matter are Rear Admiral (RADM) McGinnis (Functional) and Mr. Gunther Zimmerman (Audit Liaison). RADM McGinnis may be reached at (704) 681-2867, or Thomas.McGinnis@tma.osd.mil. Mr. Zimmerman may be reached at (703) 681-4360, or Gunther.Zimmerman@tma.osd.mil

  
Jonathan Woodson, M.D.

Attachments:  
As stated

**GAO Draft Report Dated August 20, 2013  
GAO-13-808 (GAO CODE 291102)**

**"DEFENSE HEALTH CARE: Evaluation of TRICARE Pharmacy Service Contract  
Structure is Warranted"**

**DEPARTMENT OF DEFENSE COMMENTS  
TO THE GAO RECOMMENDATION**

The GAO recommends that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to take the following two actions:

**RECOMMENDATION 1:** Conduct an evaluation of the potential costs and benefits of alternative contract structures for the TRICARE pharmacy services contract.

**DoD RESPONSE:** DoD concurs and offers the following comments.

DoD has evaluated alternative contract structures over a 15-year period through its extensive experience with several alternatives including; 1) a totally carved-in structure, 2) a partially carved-in structure (retail in the Managed Care Support Contracts), and 3) carved-out structure (current TRICARE pharmacy contract and upcoming pharmacy contract (TPharm 4)). Based on evaluation of valid information regarding costs and benefits of each alternative gained through years of experience with all three alternatives, DoD is confident that the costs and benefits of the carve-out contract structure is the most cost efficient and beneficial.

There are no supporting data to validate inferences that carving the pharmacy benefit back into the Managed Care contracts entirely or partially would result in cost savings to the government nor would it provide managerial or beneficiary advantages. A cost comparison of the value of a new carved-in scenario vs. the current carved out scenario could only be achieved through full development of two separate and complete Request for Proposals. Only after, then could a carved-in scenario be considered as a viable alternative to the current structure.

**RECOMMENDATION 2:** Incorporate such an evaluation into acquisition planning.

**DoD RESPONSE:** DoD concurs, and has included evaluation of the experience gained through alternative contract structures into acquisition planning, most recently into the upcoming pharmacy contract (TPharm4).

# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Debra A. Draper, (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Janina Austin, Assistant Director; Lisa Motley; Laurie Pachter; Julie T. Stewart; Malissa G. Winograd; and William T. Woods made key contributions to this report.

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